Appendix A: Oregon CCBHC Standards

Oregon Standards for Certified Community Behavioral Health Clinics (CCBHCs)

Senate Bill 832 directed the Oregon Health Authority (OHA) to develop standards for "achieving integration of behavioral health services and physical health services in Patient-Centered Primary Care Homes (PCPCH) and Behavioral Health Homes (BHH)." OHA relied upon the expertise of the PCPCH Standards Advisory Committee (committee) to advise in the development of integration standards. The committee developed BHH model with over 40 specific measures that provides a framework for integrating physical health services into behavioral health care settings. At this time there is no BHH recognition from the state akin to PCPCH recognition. Therefore, to align this work with the CCBHC demonstration, **organizations applying to become a CCBHC in Oregon must meet 9 Oregon Standards for CCBHCs which have adapted from the BHH model in addition to the federal CCBHC standards.**

1. **Telephone and Electronic Access** - CCBHC provides continuous access to behavioral health advice by telephone.

2. **Performance and Clinical Quality** – CCBHC tracks one quality metric from the core or menu set of PCPCH Quality Measures. See appendix for list of measures.

3. **Provision of Services** – CCBHC reports that it routinely offers all of the following categories of BH services: screening, assessment and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services and psychiatric rehabilitation.

4. **Coordination and Integration with Primary Care** – CCBHC has primary care services onsite at least 20 hours a week and has a process to insure patients can access primary care services during the hours onsite primary care is not available.

5. **Organization of CCBHC Information** – CCBHC maintains a health record for each consumer that contains at least the following elements: problem list, medication list, medication list, allergies, basic demographic information, preferred language, and updates this record as needed at each visit.

6. **Specialized Care Setting Transitions**- CCBHC has a written agreement with its usual hospital providers or directly provides routine hospital care.

7. **Care Coordination** – CCBHC demonstrates that members of the health care team have defined roles in care coordination for consumers and tell each consumer or family the name(s) of the team member(s) responsible for coordinating his or her care.

8. **End of Life Planning** – CCBHC has a process to offer or coordinate hospice and palliative care and counseling for consumers and families who may benefit from them.
9. **Language and Cultural Interpretation** – CCBHC offers and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice.

1. Telephone and Electronic Access - CCBHC provides continuous access to behavioral health advice by telephone.

Intent
Access to behavioral health advice outside of in-person office visits is an important Certified Community Behavioral Health Clinic function associated with decreased emergency and urgent care utilization. The intent of this standard is to ensure that CCBHC consumers, caregivers and families can obtain behavioral health advice via telephone from a live person at all times.

Specifications
To meet this standard the CCBHC must have 24 hour a day, 7 days a week access to a live person via telephone for behavioral advice for all consumers of the clinic. Clinic must have documented policy and procedures, including provider expectations for workflow and EHR access (if applicable) to ensure all after hours telephone encounters are documented in the EHR or paper chart within 24 hours of the call. It is not required that the person receiving the call or giving clinical advice has real-time access to the consumer's medical record, although this would be ideal.

Examples
Practice strategies meeting the intent of this standard:

- Business and after-hours phone calls answered by a live person and referred to a behavioral health clinician for clinical advice as appropriate.
- Business and after-hours phone calls answered by an on-call provider
- Business and after-hours phone calls answered by a live answering service with triage of appropriate call to an on-call clinician

Practice strategies NOT meeting the intent of this standard:

- Routine use of an answering machine to answer phone calls during or after business hours with no options for patients to access behavioral health advice from a live person.
- Use of an automated message referring patients to the emergency room or an urgent care practice during or after business hours.
- Use of non-clinical staff (e.g. receptionist) to answer phone calls if staff do not have real time access to a clinician as dictated by appropriate protocols.

2. Performance and Clinical Quality – CCBHC tracks one quality metric from the core or menu set of PCPCH Quality Measures.

Intent
Measuring and improving on clinical quality is a foundation element of Certified Community Behavioral Health Clinics. The intent of this standard is to demonstrate the CCBHCs have the capacity to monitor clinical quality data and improve their performance where appropriate.

Specifications
See appendix at end of this document for list of eligible quality measures. Detailed specifications for each measures can be found in the PCPCH Quality Measures section of the PCPCH Technical Assistance Guide. The CCBHC can track any one of the 29 measures listed.

CCBHCs may collect quality data either by querying an EHR or by manual audit of an electronic or paper chart (a chart review). CCBHCs can also use quality measures produced from claims data by a 3rd party (IPA, health plan, etc.). CCBHC must aggregate the data across all providers and consumers in the practice.

CCBHCs must use the exact specifications for calculating and reporting their data. When auditing charts manually or by query of and EHR, clinics must include in the sample all eligible patients during the sample period.

3. Provision of Services – CCBHC reports that it routinely offers all of the following categories of BH services: screening, assessment and diagnosis including risk assessment, person-centered treatment planning, outpatient mental health services, targeted case management services and psychiatric rehabilitation.

Note: This standard aligns with CCBHC Program Requirement 4 - Scope of Services with some key differences. CCBHC standards requires that clinics either directly provide these services or provide them through referral with relationships with other providers, while the BHH standard, as currently written, require the clinic to directly provide the services listed. Another difference is that the CCBHC criteria include additional services not required by the BHH standard such as provision of substance use services, crisis mental health services, peer support and counselor services, etc.

4. Coordination and Integration with Primary Care – CCBHC has primary care services onsite at least 20 hours a week and has a process to insure patients can access primary care services during the hours onsite primary care is not available.

Intent – Many Oregonians with a behavioral health condition are not accessing primary care services. Integrating behavioral health with primary care opens the door to both physical and behavioral health care in a setting that is familiar to a person with a behavioral health condition. A consumer that chooses a Certified Community Behavioral Health Clinic as their "home" should have all their healthcare needs provided at that home.

To meet this standard, there needs to a high level of collaboration and integration between behavioral health and primary care providers. The behavioral health and physical health providers function as a team with frequent personal communication. The team actively seeks system solutions as it recognizes the barriers to care integration for a broader range of consumers. Providers understand the different roles team members need to play and have started to change their practice and structure of care to achieve consumer goals. Consumers view the operation as a single health system treating the whole person. (From Center for Integrated Health Solutions)

Collaboration and integration is defined in the AHRQ lexicon for behavioral health and primary care as the integration as a practice team of primary care and behavioral health clinicians working together with patients and families, using a systematic and cost-effective approach to provide patient-centered care for a defined population. This care may address mental health and substance abuse conditions, health behaviors (including their contribution to chronic medical illnesses), life stressors and crises, stress-related physical symptoms, and ineffective patterns of health care utilization.

Specifications – CCBHC has primary care providers (PCP) onsite at least 20 hours a week offering services for physical health, disease prevention and treatment. PCP can be contracted. Categories of service should include:

- Acute care for minor illnesses and injuries
- Ongoing management of chronic diseases including coordination of care
- Office based procedures and diagnostic tests
- Patient education, prevention and wellness support services
- Care management, understood as individualized, person-centered planning and coordination to increase consumer participation and follow-up with all PC screening, assessment and treatment services

Rural clinics with critical access shortages may be able to substitute a portion of the required 20 hours of on-site primary care using telehealth. Please contact the program for more information.

CCBHC must demonstrate evidence of collaborative provider relationships and care coordination for patients receiving primary care services off-site during hours that primary care providers are not available at the CCBHC.

CCBHC has a registry/tracking system for physical health needs/outcomes.

Examples:
Practice strategies meeting the intent of this standard:

- Primary care physician (MD, DO, ND) Physician Assistant (PA), or Medical Nurse Practitioners (NP) are available at least 20 hours a week to provide primary care services.
- CCBHC providers names of primary care providers commonly used by the CCBHC and documentation in the medical record detailing collaboration with these providers such as telephone encounters, discussing particular patients, shared protocols for medical management or regular meeting times.
- Examples of regular two-way communication with these providers in patient charts demonstrating active coordination of patient care.

Practice strategies NOT meeting the intent of this standard:

- BH and PC providers work at separate facilities and have separate communication systems.
- Providers view each other as resources and communicate periodically about shared consumers and it is driven by specific issues or provider's need for specific information about a mutual consumer. (e.g. PCP requests a copy of a psychiatric evaluation to know if there is a confirmed psychiatric diagnosis).
- BH and PC are co-located in the same facility and providers still use separate systems or are starting to use some shared systems. Communication is more regular due to proximity of providers with an occasional meeting to discuss shared consumers. Movement of consumers between practices is most often through a referral process. There is some attempt for BH and PC providers to work as a team but how the team operates is not clearly defined leaving most decisions about consumer care to be made independently by individual providers.

5. Organization of CCBHC Information – CCBHC maintains a health record for each consumer that contains at least the following elements: problem list, medication list, allergies, basic demographic information, preferred language, and updates this record as needed at each visit.

Intent
Certified Community Behavioral Health Clinics must maintain comprehensive and up-to-date patient records that are easily transmissible to other clinicians and facilities as consumers move throughout the health care system. Maintaining a health record with up-to-date information is an essential perquisite to managing safe transitions of care between providers. This measure does require standardized collection of the above elements, but is not intended to require an electronic health record. CCBHC standards do require clinics to have an electronic health record.

Specifications
Clinics must be able to provide examples of all of the required elements and be able to demonstrate a process for how these elements are regularly assessed and updated by practice staff. Documentation of each element must be standardized across all consumer records. Clinics are not expected to calculate the percentage of complete consumer records or demonstrate that every element is complete in each record.

Examples
Examples of strategies meeting the intent of this standard include:

- Required elements are located in a consistent place in paper charts or in discrete fields in an EMR.
- Practice has a clear process and demonstrates the above data elements are reviewed and updated regularly (e.g. provider reviews medications at each visit, front desk staff verifies demographic information at check-in)

6. **Specialized Care Setting Transitions**- CCBHC has a written agreement with its usual hospital providers or directly provides routine hospital care.

Intent
Care coordination and communication during care transitions is an important aspect of patient safety, especially between inpatient and outpatient care settings. CCBHCs should take responsibility for facilitating appropriate transitions of care by developing working relationships with their usual providers of hospital care.

Specifications
Definition of Usual Hospital Providers -The hospital(s) or hospitalist group(s) that most frequently cares for the Certified Community Behavioral Health Clinic's consumer population when admitted to a hospital or visiting the Emergency Room.

Clinics meeting the intent of this standard must be able to identify the usual providers of hospital care for their consumers (e.g. a specific hospital(s) or hospitalist group(s)) and have a written agreement in place with the
usual hospital providers so that the Certified Community Behavioral Health Clinic is notified when consumers are admitted and discharged. Written agreements with usual providers of hospital care should contain the following types of information:

- Process for requesting hospital admission
- Process and performance expectations for communication at the time of hospital admission
- Process for sharing of patient medical records at the time of hospital admission
- Process and performance expectations for communication at the time of hospital discharge
- Process and performance expectations for scheduling after-hospital follow up appointments

Note: CCBHCs that have clinicians providing their own hospital care routinely for clinic patients do not need to have a written agreement in place. However, if a clinic is part of a system that includes a hospital, the clinic must still have a written agreement unless clinicians at the CCBHC clinic provide hospital care routinely for their consumer population.

7. **Care Coordination** – CCBHC demonstrates that members of the health care team have defined roles in care coordination for consumers and tell each consumer or family the name(s) of the team member(s) responsible for coordinating his or her care.

Intent
Care coordination is an essential feature of a Certified Community Behavioral Health Clinic. The intent of this standard is to ensure that Certified Community Behavioral Health Clinics deliberately consider care coordination functions, explicitly assign these functions to specific staff members, take extra steps to coordinate the care of consumers with complex care needs and communicate clearly to consumers who they can contact at the clinic to help coordinate their care.

CCBHC must be able to identify person(s) responsible for care coordination, provide a written description of their role/functions and a method for notifying patients of who is responsible for coordinating their behavioral health and primary health care.

Specifications
This standard requires both clear assignment of care coordination responsibilities to practice staff and clear communication to consumers about how to obtain these services. All care coordination functions within the practice do not need to be assigned to a single person. Some care coordination activities may be performed by clinical staff (e.g. motivational interviewing, support of behavior change, patient education) while others may be performed by non-clinical staff (follow up on referral and test results). However, consumers should be informed of who is responsible for their coordination needs.

Examples
A CCBHC could demonstrate meeting this standard through the following kinds of activities:

- Written job descriptions assigning certain care coordination functions to particular staff
- Demonstration that certain staff members perform care coordination (e.g staff member X maintains a log tracking test results)
- Clear verbal or written instructions are provided to consumers on who to contract to follow-up or obtain needed services.

8. **End of Life Planning** – CCBHC has a process to offer or coordinate hospice and palliative care and counseling for consumers and families who may benefit from them.

Intent
Arranging for culturally appropriate end-of-life and palliative care is an important aspect of care coordination for consumers, caregivers, and families. This standard is intended to ensure that Certified Community Behavioral Health Clinics engage their consumers, caregivers, and families in end of life discussions, routinely assess consumers' need and eligibility for hospice or palliative care when appropriate, and refer consumers for these services or coordinate services within the clinic. It is also important for clinics to ensure consumers wishes are documented in advance directive forms available in the consumer's medical record or through provider orders recorded in the medical record (i.e. POLST) which reflect the consumer's wishes for their end-of-life care

Specifications
POLST – Physician Orders for Life-Sustaining Treatment

CCBHCs are not required to directly provide hospice or palliative care, but must have a process in place to refer and coordinate those service when consumers and families need them.

Examples
Activities meeting the intent of this standard could include:

- List of usual referral provider for hospice or palliative care (including admission criteria for these providers) and examples of consumers referred to hospice or palliative care
- Examples of encounters for consumers regarding hospice or palliative care referral
- Examples of hospice or palliative care plans developed or approved by CCBHC providers

9. **Language and Cultural Interpretation**- CCBHC offers and/or uses either providers who speak a consumer's and family's language at time of service in-person or telephonic trained interpreters to communicate with consumers and families in their language of choice.

Intent
Cultural and linguistic proficiency is a core component of person and family centered care. The intent of this standard is to ensure that Certified Community Behavioral Health Clinics communicate with consumers, caregivers, and families in their language of choice using trained medical interpreters. Further, there is a strong evidence base supporting the benefits of translating written materials.

Specifications
Clinics must be able to produce a list of interpreter services used at the clinic and written guidelines for providing services to consumers in the language of their choice.

Interpretation services should be offered either on-site or telephonically for all consumers at the clinic that speak languages other than English and must be provided free of charge to consumers. Interpretation services should be offered and available during the consumers' entire office visit and for telephone encounters. Consumers may decline the use of interpreters, but should be informed that interpreters are available free of charge and have distinct advantages. Some clinics ask consumers who refuse interpretation services to sign a waiver.

Examples
The following kinds of activities would meet the intent the standard:

- Use of bilingual staff to communicate with consumers or family members in their language(s) of choice throughout their entire office visit and during telephone encounters.
- Use of a real-time telephonic interpreter (e.g., Passport to Languages, Pacific Interpreters, Language Line Solutions, etc.) to communicate with consumers in their language of choice throughout their entire office visit and/or during telephone encounters.
- Use of an in-person interpreter to communicate with consumers in their language of choice throughout their entire office visit and/or during telephone encounters.

The following kinds of activities would NOT meet the intent the standard:

- Routine use of consumer family members to act as interpreters for non-English speaking patients.
- Interpreter services, providers, or other employees acting as translators, available at some times during clinic business hours, but not available at other times and the clinic does not have a strategy to provide alternative options for interpreter services the times when the employee(s) or services are unavailable and for consumers languages for which the providers or employee(s) cannot offer proficient interpretation.

APPENDIX

Overview of PCPCH Core and Menu Set Quality Measures

Adult Core Quality Measure Set

Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
1	NQF0421	BMI Screening and Follow-up	X		X	47%
2	NQF0028	Tobacco Use: Screening and Cessation Intervention	X		X	93%
3	NQF0509	Reminder System for Mammograms			X	TBD
4	NQF0032	Cervical cancer screening	X			73%
5	OHA State Performance Measure (NQF 0034)	Colorectal cancer screening	X	X		47%
6	OHA State Performance Measure (NQF 0057)	Comprehensive Diabetes Care: Hemoglobin A1c testing		X		86%
7	NQF0575	Comprehensive Diabetes Care: HbA1c control	X			60%
8	OHA State Performance Measure (NQF 0018)	Controlling High Blood Pressure		X		64%

Pediatrics Core Quality Measure Set						
Measure #	**Source**	**Measure**	**UDS (FQHCs)**	**OHA State Performance Measure**	**Meaningful Use**	**Benchmark**
9	NQF0024	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	X		X	43%
10	OHA State Performance Measure (NQF0038)	Childhood Immunization Status	X	X		82%
11	NQF0036	Use of Appropriate Medications for People with Asthma	X			91%
12	OHA State Performance Measure (NQF1399)	Developmental screening in the first 3 years of life		X		50%
13	OHA State Performance Measure (NQF 1392)	Well child care (0 – 15 months)		X		77%
14	NQF 1516	Well child care (3 – 6 years)				74%
15	OHA State Performance Measure (CHIPRA Core Measure #12)	Adolescent well-care (12-21 years)		X		53%

Menu Quality Measure Set[1]						
Measure #	Source	Measure	UDS (FQHCs)	OHA State Performance Measure	Meaningful Use	Benchmark
16	OHA State Performance Measure (NQF 0418)	Screening for clinical depression		X		25%
17	OHA State Performance Measure (NQF 1517)	Prenatal and Postpartum Care – Prenatal Care Rate		X		69%
18	OHA State Performance Measure (NQF1517)	Prenatal and Postpartum Care – Postpartum Care Rate	X	X		66%
19	OHA State Performance Measure (NQF0002)	Appropriate testing for children with pharyngitis		X		76%
20	NQF0043	Pneumonia vaccination status for older adults				TBD
21	NQF0044	Pneumonia Vaccination				TBD
22	NQF0041	Influenza Immunization				TBD
23	NQF0066, 67,70, 74	Chronic Stable Coronary Disease				NQF 0070, 83%
24	OHA State Performance Measure	Screening, Brief Intervention, Referral for Treatment (SBIRT): Alcohol Misuse		X		13%
25	NQF0061	Comprehensive Diabetes Care: Blood Pressure Control	X			67%
26	NQF0064	Comprehensive Diabetes Care: LCL-C Control	X			40%

[1] Note: Any additional adult or pediatric core measure that a practice tracks can be used as a menu set measure.

27	OHA State Performance Measure (NQF0108)	Follow-up care for children prescribed ADHD medication		X		Initiation: 51% Continuation & Maintenance: 63%
28	OHA State Performance Measure (NQF 1407)	Adolescent immunizations up to date at 13 years old		X		70%
29	OHA State Performance Measure (NQF0063)	Comprehensive Diabetes Care: Lipid LDL-C Screening		X		80%

Appendix B: Oregon Administrative Rules

Chapter 409
OREGON HEALTH AUTHORITY,
HEALTH POLICY AND ANALYTICS
DIVISION 62

Certified Community Behavioral Health Clinic Program
409-062-0000
Purpose and Scope

These rules establish the Certified Community Behavioral Health Clinic (CCBHC) program and define the criteria and process that the Authority shall use to recognize and verify status as CCBHCs. These rules specify the standards for the CCBHC application and certification process. In addition to meeting all state and federal criteria, only organizations certified under OAR 309-019-0100 to 309-019-0220 (Outpatient Addictions and Mental Health Services) and OAR 309-008-0100 to 309-008-1600 (Standards for Certification of Behavioral Health Treatment Services) may become certified.
Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042

409-062-0010
Definitions

The following definitions apply to OAR 409-062-0000 to 409-062-0060:
(1) “Authority” means the Oregon Health Authority.
(2) “CCBHC” means the Certified Community Behavioral Health Clinic.
(3) “CCBHC application” means the survey link that is posted on the CCBHC program website.
(4) “Certification” means the process which the Authority uses to determine if a practice has met the criteria in the document titled “Criteria for the Demonstration Program to Improve Community mental Health Centers and to Established Certified Community Behavioral Health Clinics” as well as the Oregon state CCBHC standards.

(5) “Certified” means that the Authority has affirmed that a practice substantially meets the federal and Oregon CCBHC standards
(6) “Practice” means an individual, facility, institution, corporate entity, or other organization which provides direct health care services or bills, obligates and receives reimbursement on behalf of a performing provider of services, also termed a billing provider (BP). The term provider refers to both performing providers and BPs unless otherwise specified.
(7) “Program” means activities associated with the CCBHC planning grant.
(8) “Program website” means http://www.oregon.gov/oha/bhp/Pages/Community-BH-Clinics.aspx.
(9) “Verification” means the process that the Authority shall conduct to ensure that a practice has submitted accurate information to the Authority for purposes of CCBHC certification.
Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042

409-062-0020
Program Administration
(1) The Program shall develop and implement a uniform application and process for certifying CCBHCs throughout the state of Oregon.
(2) The Authority shall recognize practices as certified CCBHCs upon meeting criteria set forth in OAR 409-062-0040.
(3) The Authority shall administer the Program, including data collection and analysis, recognition, and verification that a practice meets the defined CCBHC criteria.
(4) The Authority may also provide technical assistance.
Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042

409-062-0030
Application and Certification Process
(1) To be certified as a CCBHC, practices or their designee shall submit a CCBHC application electronically to the Authority using the Program’s online

application system found on the program website or by mail to the address posted on the program website which shall be open for 30 days. The Authority may choose to extend the application period beyond 30 days.
(2) The Authority shall review the application within 30 days of its submission to determine whether it is accurate, complete, and meets the certified requirements. If the application is incomplete the Authority shall notify the applicant in writing of the information that is missing and when it must be submitted.
(3) The Authority shall review a complete application within 45 days of submission. If the Authority determines that the applicant has met the requirements of these rules the Authority shall:

(a) Inform the applicant in writing that the application has been approved as a potential CCBHC;

(b) Assign a preliminary level of readiness for certification; and

(c) Include information regarding site visit planning, including, but not limited to, needs assessment requests, an anticipated agenda, schedule, and materials required for site visit.

(4) The Program shall post instructions and criteria for submitting a CCBHC application on the Program website.
(5) The Authority may deny CCBHC certification if an applicant does not meet the requirements of these rules.
(6) A practice may request that the Authority reconsider the denial of CCBHC recognition or reconsider the assigned level of readiness.

(a) A request for reconsideration must be submitted in writing to the Authority within 30 days of the date of the denial or approval letter and must include a detailed explanation of why the practice believes the Authority's decision is in error along with any supporting documentation.

(b) The Authority shall inform the practice in writing whether it has reconsidered its decision.

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042 4

409-062-0040
Certification Criteria
A practice seeking CCBHC certification must meet the following criteria:
(1) Complete CCBHC application process, meeting the "ready to certify" or "mostly ready to certify" designation;
(2) Meet all federal criteria stated in the document titled "Criteria for the Demonstration program to Improve Community mental health Centers and to Establish Certified Community Behavioral Health Clinics";
(3) Meet all Oregon criteria stated in the Oregon CCBHC standards;
(4) Agree to a verification site visit and follow up activities with the CCBHC site review team; and
(5) Agree to contributing to and participating in the statewide needs assessment process.
Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042

409-062-0050
Level of Readiness Designation
(1) The Authority shall award three levels of readiness designations to practices implementing multiple advanced CCBHC measures, including:
(a) Ready to certify: Currently meets the required criteria.
(b) Mostly ready to certify: Currently meets the majority of required criteria and has plans and a timeline in place to meet remaining required criteria.
(c) Mostly ready to certify with assistance: Currently meets the majority of required criteria with needs for significant technical assistance to meet required criteria and develop a plan and timeline to meet remaining required criteria.
(2) Not ready to certify: Does not meet all certification criteria.
Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042 5

409-062-0060
Variances

(1) The Authority may grant a variance to a CCBHC applicant or provider if:

(a) There is a lack of resources to meet the criteria required in these rules; or

(b) Implementation of the proposed alternative services, methods, concepts or procedures would result of improved outcomes for the individual.

(2) CCBHC applicants must submit the variance request directly to the CCBHC project team.

(3) The request must be in writing and must contain the following:

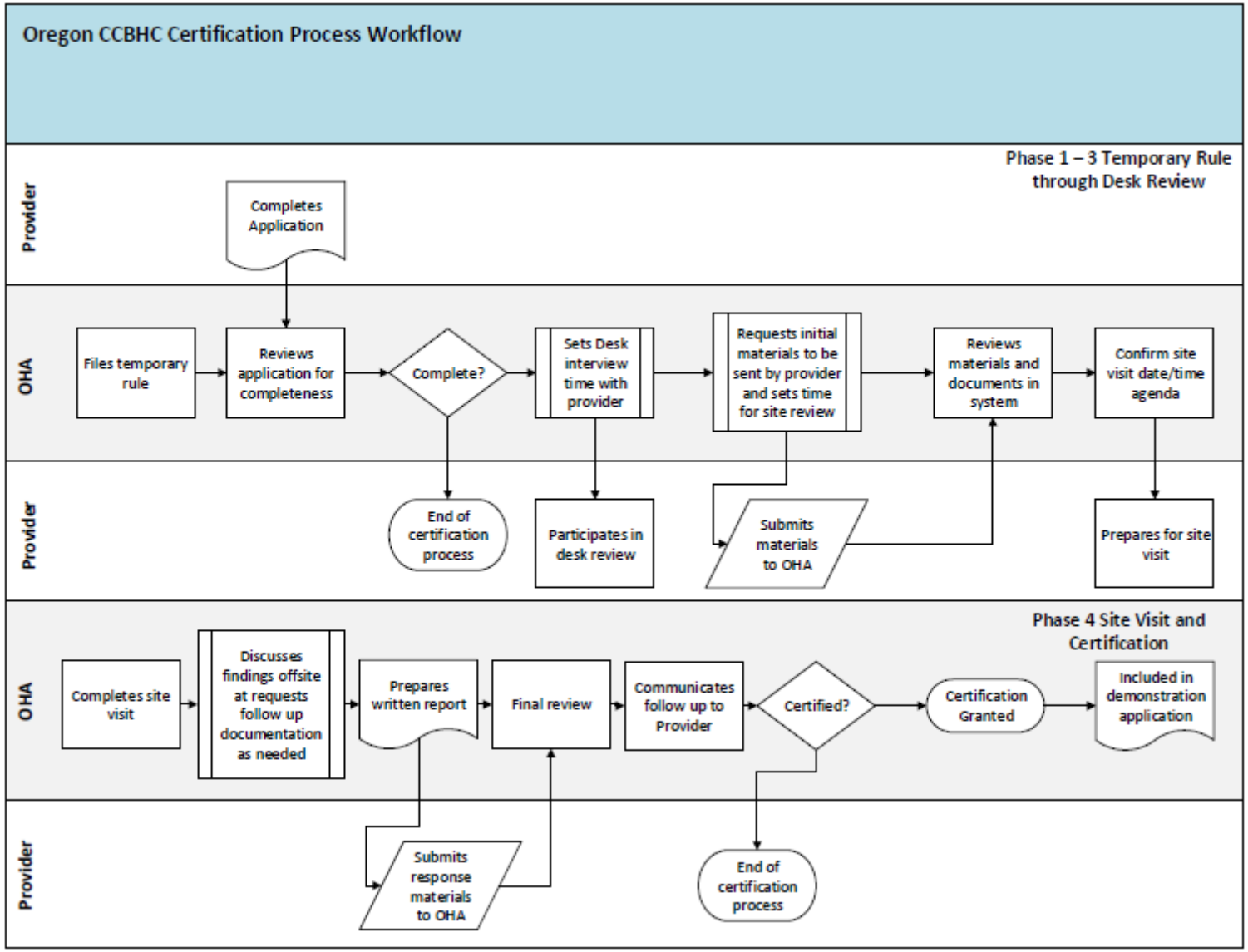
(a) Criteria from which the variance is sought;
(a) The reason for the proposed variance;
(c) The alternative practice, service, method, concept, or procedure proposed, and;
(d) A plan and timetable for compliance with the section of criteria for which the variance applies.

(4) The CCBHC principal investigator must approve or deny the request for a variance and must notify the provider in writing of the decision to approve or deny the requested variance, within 30 days of receipt of the variance. The written notification must include the specific alternative practice, service, method, concept, or procedure that is approved and the duration of the approval.

(5) Granting a variance for one request does not set a precedent that must be followed by the Authority when evaluating subsequent requests for variance.

Stat. Auth: ORS 413.042
Stats. Implemented: ORS 413.042

Appendix C: CCBHC Certification Work Flow


Oregon CCBHC Certification Process Workflow
Phase 1 – 3 Temporary Rule through Desk Review
Provider
Completes Application
OHA
Files temporary rule
Reviews application for completeness
Complete?
Sets Desk interview time with provider
Requests initial materials to be sent by provider and sets time for site review
Reviews materials and documents in system
Confirm site visit date/time agenda
Provider
End of certification process
Participates in desk review
Submits materials to OHA
Prepares for site visit
Phase 4 Site Visit and Certification
OHA
Completes site visit
Discusses findings offsite at requests follow up documentation as needed
Prepares written report
Final review
Communicates follow up to Provider
Certified?
Certification Granted
Included in demonstration application
Provider
Submits response materials to OHA
End of certification process

Appendix D: Oregon Statewide Needs Assessment

Assessment of Need:
Various resources were brought together to assess need across the state of Oregon. Resources utilized include the preliminary 2015 Behavioral Health Mapping Profiles for each county in Oregon to assess statewide need, the 2015 results from the MHSIP surveys targeting adults and children, and a series of Behavioral Health Town Hall meetings held across the state in 2015. The preliminary data associated with the Behavioral Health Mapping Profiles quantified the size of unmet need in Oregon, while the MHSIP surveys track consumer satisfaction of those already receiving care. Finally, the Town Hall meetings provide a more in depth look into statewide and region specific issues in mental health care. From these three sources it became apparent that there are many in Oregon who would benefit from improved access to quality mental health resources, but that regional variation will require a multi-faceted approach to meeting the mental health needs of Oregonians.

Behavioral Health Mapping Statewide Profile:
Based on preliminary data associated with an ongoing behavioral health mapping project, OHA estimates across the state of Oregon, there is an unmet need of 322,125 Medicaid consumers requiring mental health services and 54,848 who require substance abuse services (Table 1). While a greater number of adults are in need of mental health services, the population in greatest need of substance abuse treatment was transition age youth (Table 1).

Table 1. Statewide unmet need: number of Medicaid Population

	Children (0-17)	Transition Age Youth (18-25)	Adult (26+)
Mild to Moderate # Unmet Need	X	35,924	129,859
Serious Mental Illness # Unmet Need	X	6,882	41,154
Any Mental Illness # Unmet Need	108,306	42,806	171,013
Substance Use # Unmet Need	8,278	27,481	19,089

The vast majority of those in need of mental health and substance abuse treatment are White, with Hispanics forming the second largest population in need of mental health and substance abuse treatment. Oregon is also home to a sizable Native American population, which has historically had some of the highest rates of mental health and substance abuse issues (SAMHSA, http://www.samhsa.gov/specific-populations/racial-ethnic-minority).

Table 2. Breakdown of the unmet need of Medicaid Consumers with Mental Health and Substance Use Issues by Race/Ethnicity*

	African American	Native American	Asian or Pacific Islander	White	Hispanic	Other/Unknown
Mental Health	3,728	10,213	3,141	247,859	35,761	21,382
Substance Use	1,079	3,869	628	69,141	7,866	6,031

*No information as to the percentage of Medicaid consumers receiving treatment by racial ethnic breakdown was available, these numbers assume that all races/ethnicities were treated in equal proportions.

There are an estimated 328,138 veterans living in Oregon. Of these veterans, an estimated 49,221 have mental health issues. As it is projected that only 25% of veterans with mental health issues receive adequate care, there is an estimated unmet need of 36,915 veterans for the state of Oregon.

Methodology:
The number of persons on Medicaid who have an unmet mental health need for each category were calculated by subtracting the number of people who received treatment in 2015 (% Medicaid treated* Medicaid subpopulation) from the number of people estimated to have a mental health issue in 2015 (% Medicaid population* Medicaid subpopulation). Note that mental health issues were not divided into "mild to moderate" or "serious" for children under the age of 17.

E.g. $\#\ Adults\ with\ Unmet\ Serious\ Mental\ Health\ Issue = \%\ Adults\ Estimated\ w/\ Serious\ Mental\ Health\ Issue\ \times \#\ Adults\ w/Medicaid\ -\ \%\ Adults\ Treated\ for\ Serious\ Mental\ Health\ Issue \times \#\ Adults\ w/Medicaid$

The estimated number of people in each race ethnicity with mental health and substance use disorders was calculated by multiplying that race ethnicity's percentage by the total estimated number of people with mental health or substance use disorders. Please note that this is a total number of people with mental health issues and substance disorders, and not necessarily an unmet need, as we do not have data on the breakdown of treatment by race. It is possible that some of these people are already receiving adequate care. However, if there are currently no specialized services for these race ethnicities in the area, any care they may be receiving may not be properly targeted to the needs of these groups.

The estimate of veterans with mental health issues was calculated by multiplying the veteran population in each county by 15%. This number was selected as an average between 19% and 11%, as data has shown that approximately 19% of veterans returning from the Iraq and Afghanistan wars have PTSD or depression (SAMHSA, http://www.samhsa.gov/veterans-military-families) and that approximately 11% of veterans above the age of 65 have issues with depression (Veterans Association, http://www.va.gov/health/NewsFeatures/20110624a.asp). Of veterans with mental health issues, only 50% seek out care, and it is estimated that only half that seek out care receive adequate care (SAMHSA, http://www.samhsa.gov/veterans-military-families). Therefore, veteran unmet need was estimated by subtracting the number of veterans receiving adequate care (25% of the veterans with mental health issues) from the total number of veterans with mental health issues.

MHSIP Surveys:

OHA performs an annual survey of Medicaid patients who have received mental health services using the MHSIP survey. For Adults who received outpatient treatment, the 2015 survey revealed that 75% were generally satisfied with the care they received, 66% were satisfied with the level of access to services, 73% were satisfied with the quality of care they received, but only 46% were satisfied with the outcomes of their treatment and only 46% were satisfied with their level of daily functioning. There were no significant differences in responses between rural and urban consumers, or between different age groups of consumers (transition age youth, adults, and older adults). White consumers reported higher levels of general satisfaction, satisfaction with access, and satisfaction with quality of care compared with Native Americans. However, Hispanic consumers reported higher levels of general satisfaction, satisfaction with access, and satisfaction with quality of care than non-Hispanics.

OHA also performs an annual survey of youth and their families enrolled in Medicaid who have received mental health services using the Oregon Youth Services Survey for Families (YSS-F), which has been validated by the MHSIP. For the 2015 YSS-F, 74% of children's caregivers were satisfied with access to care, and 61% were satisfied with treatment outcomes and daily functioning. There were no statistically significant differences in age groups (0-5 years, 6-12 years, and 13-17 years) or gender for these categories. However, urban caregivers had statistically significant higher satisfaction rates with treatment outcomes and daily functioning (64% and 63%, respectively) than rural caregivers (57% for both categories). There were no statistically significant differences in access by race. However, Pacific Islanders statistically had the highest satisfaction with treatment outcomes and daily functioning, while Native Americans and Whites had the lowest satisfaction with treatment outcomes and daily functioning. There were no statistically significant differences in categories based on whether a child was Hispanic or non-Hispanic. For children who were receiving services from multiple agencies, 95% of caregivers reported satisfaction with the coordination of care they were receiving from their mental healthcare providers.

Behavioral Health Town Hall Meetings:

In 2015 a series of seven town hall meetings were convened across the state of Oregon. Approximately 550 consumers and family members attended these meetings, along with

Senator Sara Gelser (D-Corvallis) and OHA Director Lynne Saxton. Town hall questions were designed to encourage open conversations about issues and challenges experienced by behavioral health consumers in Oregon. At each town hall, participants were invited to join breakout groups to discuss the needs of Children and Adolescents, Adults, Older Adults, Young Adults in Transition, Family and Friends, and other topics as requested.

The town hall meetings highlighted systemic challenges such as limited access to services, poorly trained service providers, lack of coordination among providers and other entities such as schools or law enforcement, and an overly complex administration. Access to care was a major issue for both rural/frontier and urban areas; rural areas cited difficulty with traveling long distances to access care as well as a lack of specialty services, while urban areas cited heavy competition to access a limited number of resources. Overall, there are not enough services and supports to meet current need, with provider shortages resulting in long wait times and a lack of specialty services for children. Transportation and jobs are large issues in the rural and frontier regions of Oregon, while affordable housing is a state-wide issue. Transgender and multicultural issues were also noted. Consumers highlighted issues with a lack of credible providers for transgendered consumers as well as a need for culturally specific services for refugees and culturally competent providers in general.

Consumers lauded the peer support and supported employment programs, and requested that these programs be expanded. Participants also suggested integrating physical, oral, and behavioral health services; increase access to telemedicine; increasing high quality training for providers, consumers, and families; increasing resources such as a warm line, respite care, and more hospital beds; training law enforcement and ER staff in behavioral health; have advocates available to help behavioral health consumers navigate the administrative system; and have integrated teams that include a case manager.

Addressing Need:
Oregon is certifying 14 CCHBCs, located in 14 out of Oregon's 36 counties. Four of the 14 CCBHCs serve urban populations, five serve rural populations, and five serve frontier populations. This breakdown of CCBHCs ensures that the needs of each of Oregon's three major population types (urban, rural, and frontier) will be addressed. Given the geographic distribution of the CCBHCs (Figure 1) there is little overlap in service area.

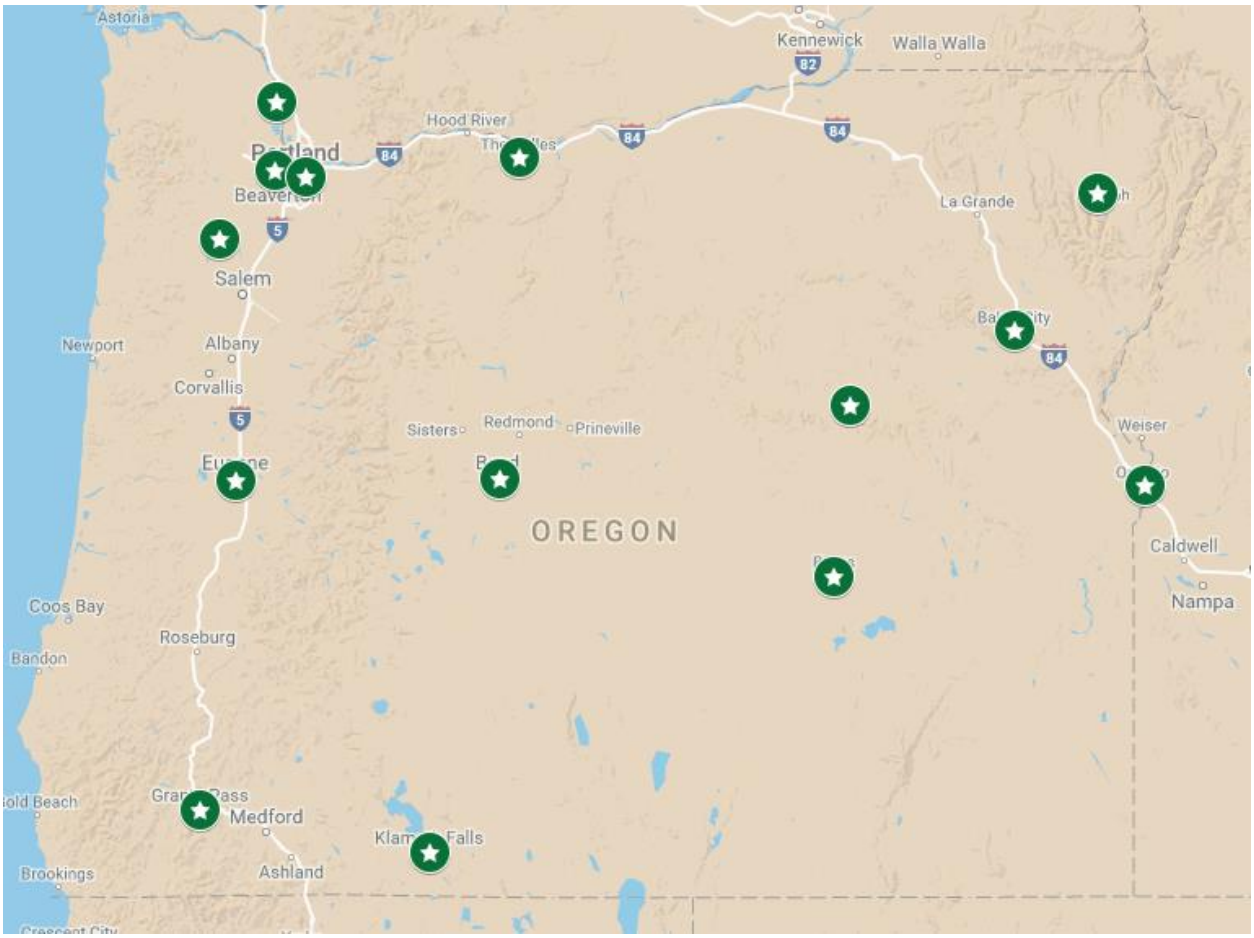


Figure 1. Map of CCBHC service locations in Oregon. There are 14 CCBHCs, some with multiple locations across the state.

Each CCBHC was required to complete a needs assessment for their service area based on the behavioral health mapping profile for their respective county/service area and any additional data available to their region. As a result of this process, Oregon's CCBHCs will be increasing services by 20-30% and will be increasing staffing by a total of 461 FTE across all CCBHCs to address workforce shortages and unmet need in their respective service areas (Table 3). Combined, the CCBHCs will hire an additional 125 clinical staff to address unmet need in children (0-17), 80 staff for transition age youth (18-25), 178 staff for adults (26-64) and 78 staff for older adults (65+). It is worth noting that the state of Oregon only has 70 psychiatrists with a child subspecialty in the state of Oregon (Behavioral Health Town Halls 2015 Report), and thus an increase in 125 clinical staff dedicated to children's issues will be a major boon to treating the unmet need for children. While one rural clinic did cite a behavioral health professional shortage in relation to hiring a psychiatrist as a Medical Director, they do have staff with the appropriate education and licensure to meet the Medical Director requirements.

Individual CCBHCs also identified local issues and populations that they wish to target, with rural/frontier clinics often citing transportation, traveling clinicians, and telehealth as an area for expansion and urban clinics often mentioning expanding services to those who live below

the poverty line and increasing multicultural services. Telehealth and telemedicine were cited as means to address workforce shortages for rural clinics. Furthermore, many individual CCBHCs mentioned expanding services for veterans, expanding interpretive services, and increasing trainings for cultural sensitivity and veteran's issues. Many clinics also either currently offer or will expand their service hours beyond regular Monday-Friday 9AM-5PM business hours.

Table 3. CCBHC Staffing and Staffing Increases

Provider Name	# of Staff (FTE)	# of Staff to be added (FTE)	% staffing increase
Cascadia	221.6	23.8	10.7
Columbia Community Mental Health	117.0	35.0	29.9
Community Counseling Solutions	13.0	2.2	16.8
Deschutes County	158.0	12.9	8.2
Klamath Basin	113.0	37.5	33.2
LifeWays	259.0	234.4	90.5
LifeWorks NW	251.0	31.0	12.4
Mid Columbia Center for Living	122.0	25.7	21.1
New Directions Northwest	26.0	1.6	6.0
Options for Southern Oregon	172.0	21.8	12.7
PeaceHealth	160.0	0.0	0.0
Symmetry Care	23.0	5.0	21.7
Wallowa Valley	28.0	6.0	21.4
Yamhill County	162.0	24.4	15.1

In addition to the CCBHC program, the state of Oregon is also implementing additional programs to help address unmet need across the state. In 2015, the Oregon Legislature provided OHA with $28 million in funding for programs for crisis, crisis respite, jail diversion, peer supports, sobering centers, and rental assistance. Oregon has a statewide crisis line, called Lines for Life, which increased the number of volunteers by 50% in 2015 to enhance its statewide suicide prevention campaign. In addition to this, Oregon also has a warm line that operates 14 hours a day, every day. The Telehealth Alliance of Oregon has also begun to compile an inventory of telehealth services in Oregon to assist consumers with finding telehealth options. Also, Oregon has recently developed the Oregon Psychiatric Access Line about Kids (OPAL-K), which allows primary care providers across the state to call child psychiatrists in Portland for consultation on medication management and treatment options. To improve services, the state of Oregon is emphasizing evidence based practices, with an emphasis on peer delivered programs and healthcare integration. Finally, the State of Oregon is developing an MOU with the VA to increase services to veterans.

Overall, the state of Oregon leveraged a number of resources, including surveys, town hall meetings, and behavioral health mapping in order to assess the current unmet need for Oregon. Through this process, OHA was able to assess a wide variety of communal needs and is

in the process of identifying and implementing the means to improve access and quality to behavioral health resources across the state. Though unmet need and resources vary widely across Oregon, by performing local needs assessments each CCBHC was able to identify local solutions that will help alleviate the need for behavioral health services in their service areas. Because Oregon is certifying 14 CCBHCs, the work of all the CCBHCs combined will be able to improve access and quality statewide.